initial problem will no longer suffice. It now takes a major change. Moreover, at this stage, the direction of any likely change is clear to everyone—in the case of Thailand, a devaluation. A speculator who sold the Thai baht short could at worst lose commissions and interest on his capital since the peg meant that he could cover his short at the same price at which he sold it if the baht was not devalued. On the other hand, a devaluation would bring large profits.

Many of those responsible for the East Asia crisis have been unable to resist the temptation to blame speculators for their problems. In fact, their policies gave speculators a nearly one-way bet, and by taking that bet, the speculators conferred not harm but benefits. Would Thailand have benefited from being able to continue its unsustainable policies longer?

Capital controls and unified currencies are two ways out of the trilemma. The remaining option is to let exchange rates be determined in the market predominantly on the basis of private transactions. In a pure form, clean floating, the central bank does not intervene in the market to affect the exchange rate, though it or the government may engage in exchange transactions in the course of its other activities. In practice, dirty floating is more common: The central bank intervenes from time to time to affect the exchange rate but does not announce in advance any specific value that it will seek to maintain. That is the regime currently followed by the U.S., Britain, Japan and many other countries.

FLOATING RATE

Under a floating rate, there cannot be and never has been a foreign exchange crisis, though there may well be internal crises, as in Japan. The reason is simple: Changes in exchange rates absorb the pressures that would otherwise lead to crises in a regime that tried to peg the exchange rate while maintaining domestic monetary independence. The foreign exchange crisis that affected South Korea, Thailand, Malaysia and Indonesia did not spill over to New Zealand or Australia, because those countries had floating exchange rates.

As between the alternatives of a truly fixed exchange rate and a floating exchange rate, which one is preferable depends on the specific characteristics of the country involved. In particular, much depends on whether a given country has a major trading partner with a good record for stable monetary policy, thus providing a desirable currency with which to be linked. However, so long as a country chooses and adheres to one of the two regimes, it will be spared foreign-exchange crises and there will be no role for an international agency to supplement the market. Perhaps that is the reason why the IMF has implicitly favored pegged exchange rates.

The present crisis is not the result of market failure. Rather, it is the result of governments intervening to or seeking to supersede the market, both internally via loans, subsidies, or taxes and other handicaps, and externally via the IMF, the World Bank and other international agencies. We do not need more powerful government agencies spending still more of the taxpayers' money, with limited of nonexistent accountability. That would simply be throwing good money after bad. We need government, both within the nations and internationally, to get out of the way and let the market work. The more that people spend or lend their own money, and the less they spend or lend taxpayer money, the better.

MENTAL HEALTH CRISIS

HON. MARGE ROUKEMA

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 13, 1998

Mrs. ROUKEMA. Mr. Speaker, I am pleased to take this time (with the gentlelady from Ohio, Ms. KAPTUR) to illuminate what needs to be done to address the silent medical crisis in America of mental illness.

Mental illness is not a character flaw, but a tangible treatable health problem as real as hypertension or heart disease or tuberculosis or the many forms of cancer.

The good news: advances of our medical system have provided scientific breakthroughs that make appropriate mental health care as effective as insulin for a diabetic.

While we do have the ability to treat mental illness, we have a tremendous amount of work to do in the critical area of public understanding of mental illnesses—leading to appropriate treatment.

Unfortunately, America is witnessing more violence every day resulting from untreated mental illness and a failed policy of deinstitutionalization without any proper community follow-up.

All too often we hear of situations where an individual with a mental disorder has not received adequate treatment and has reacted violently and endangered him—or herself or, tragically, taken the life of another. Last year, alone, over 1,000 homicides were directly attributable to improperly treated mental illnesses.

This crisis is not just a crisis for adults. This crisis also affects our children.

The American Academy of Child & Adolescent Psychiatry estimates that 12 million American children have a mental illness at any one time, but fewer than one in five is identified as needing treatment. Early diagnosis, follow-up treatment, and prevention and intervention programs can help children and adolescents at risk for violent incidents.

My colleagues, these are the dimensions of this silent crisis. But we are not powerless. We can do something.

I, along with Representative KAPTUR, have introduced a sense of the House resolution to establish a mental illness working group to probe the gaping holes in the network of services designed to identify, assist, and treat those people with mental illness.

While treatment of the mentally ill is primarily a function of the separate states, there does exist significant sharing of costs and some joint federal/state responsibilities in such areas as reciprocity between states, the relationship of SSI and Medicaid to mental illness and the designation of Institutions of Mental Diseases.

Other key federal components that require oversight and analysis are the effectiveness of mental health block grants and the federal prison costs attributed to mental illness.

Our proposed mental illness working group would be charged with gathering information about the nature of the problem, current state and federal policy gaps as well as reviewing the need for reciprocity and how states and communities failed to provide follow-up treatments to these individuals.

This will involve Members of the various Committees that have jurisdiction over federal issues involving the mentally ill, including Ways and Means, Judiciary, Commerce, Veterans Affairs, Appropriation, Banking and the Education and the Workforce Committee. They are involved in issues ranging from discrimination in health care coverage to public housing.

We must take responsible action and seize this opportunity to ensure that something beneficial results from recent tragedies, such as that which occurred here on Capitol Hill.

I hope you will join us in this effort.

OPPOSING REPUBLICAN LAST MINUTE EFFORTS TO PASS A MODIFIED VERSION OF H.R. 4006, THE LETHAL DRUG ABUSE PREVENTION ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 13, 1998

Mr. STARK. Mr. Speaker, I rise to express my strong opposition to attempts that I understand are currently underway to attach a version of H.R. 4006, The Lethal Drug Abuse Prevention Act of 1998, to the omnibus appropriations bill that will soon be considered by Congress.

H.R. 4006 has been scheduled for floor consideration by the Full House several times this year. Each time ti has been pulled from consideration because of the great concerns expressed by our medical community. The bill purports to simply combat the practice of physician-assisted suicide. Unfortunately, that is not all the bill accomplishes. It also presents real barriers to the appropriate care of terminally ill and dying patients.

It does not appear that the supporters of this legislation intend to affect pallative care for the dying. But, regardless of intent, it is the effect of this bill. The latest version of the bill would have the same result.

If it becomes law, doctors will be deterred from providing appropriate pain management to their terminally ill patients. If you've ever lost a loved one after a long, painful illness, you know the importance of these medications. They are vital to ease the pain of people in their final days of life. It should be up to the patient, the doctor, and the patient's family to develop an appropriate pain management program—without the doctor needing to fear intervention from the federal government.

The tools exist today at the state level through the State medical and pharmacy boards to seek out and discipline doctors and other health care providers that violate the law regarding the dispensing of controlled substances. This legislation is not necessary.

The medical community is opposed to this action and patient advocacy groups are opposed to it as well. In total, more than 55 such organizations have signed up to express their opposition. The Department of Justice, the very agency that would be required to enforce the policy if it were to become law, has also voiced strong opposition to this action. In a letter to Chairman Hyde regarding H.R. 4006, the Departments states: ''Virtually all potent pain medications are controlled substances. Thus, physicians who dispense these medications to ease the pain of terminally ill patients could well fear that they could be the subject